Clear Form

ACCIDENTAL DISMEMBERMENT OR LOSS OF SIGHT CLAIM FORM

THE HARTFORD

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

TO BE COMPLETED BY THE CLAIMANT OR HIS/HER REPRESENTATIVE *(Please answer all questions.)*

1. Claimant's name _____ _____ Age _____
   (Please Print) *(Phone: Area Code & Number)*
2. Present address _____
   (Number) *(Street)* *(City)* *(State)* *(Zip Code)*
3. When did the accident happen? Date _____ at _____ { a.m. / p.m.
   (Hour)
4. Where did the accident happen? City _____ State _____
5. Give a brief description of the accident _____
6. Do you carry any other accident insurance? ☐ Yes ☐ No If "Yes," list companies. _____

I hereby authorize any physician who has attended me or may attend me, or any hospital where I may have been a patient, or any other individual or association who may have given me medical treatment or supplies to disclose any information thus acquired to The Hartford. My consent is hereby granted to use this original or a photostatic copy as equally valid authorization.

Date _____ Signed _____
Claimant (or his/her representative, if unable to sign)

TO BE COMPLETED BY THE BENEFITS ADMINISTRATOR *(Please answer all questions.)*

1. Employee's name _____ Social Security Number _____
2. Amount of Accidental Dismemberment Benefit $ _____ **GL 33913** Effective date _____
   Amount of Accidental Dismemberment Benefit $ _____ **GL 674267** Effective date _____
3. If this coverage has been cancelled, give the date and reason _____
4. (a) Date of hire _____ (c) Date last worked _____
   (b) Date returned to work _____ (d) Basic earnings on last day worked $ _____
5. Has this claim been considered in connection with Workers' Compensation claim? ☐ Yes ☐ No
   If "Yes," what is the present status of the compensation claim? _____
6. Give any information which might assist in the consideration of this claim? _____
7. Please attach (a) copy of your accident report and any newspaper clippings giving details of the accident
   (b) copy of this employee's insurance enrollment form.

Date _____

Employer **SC Budget and Control Board Employee Insurance Program** _____
Entity: *Phone: Area Code & Number*

Entity Name: _____ Signed: _____

Entity Address: _____ Title _____

TO BE COMPLETED BY ATTENDING PHYSICIAN ***(Please answer all questions.)***

1. Name of patient _____ Age _____

2. (a) Date first consulted on account of the injury described _____

   (b) Date of last treatment _____

3. Describe the exact nature, location, and extent of all injuries sustained _____

_____

TO BE COMPLETED ONLY FOR LOSS OF VISION

4. (a) Which limbs were severed or amputated?

(b) State the dates on which the severances or amputations occurred.

(c) State the exact point at which the amputation was performed or the severance occurred with respect to each limb lost. If the severance or amputation was below the elbow or kneejoint, indicate on the chart the exact point of severance.

5. State the causes of the amputation.

6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated, or examined.

7. Please give the names of such other physicians as have attended this patient and the dates of their first and last treatments as reported to you.

4. Give the date you first determined vision was irrevocably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

(a) Date _____

(b) (Snellen Notations)

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

5 Give the date and vision found on last eye examination.

(a) Date _____

(b) (Snellen Notations)

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

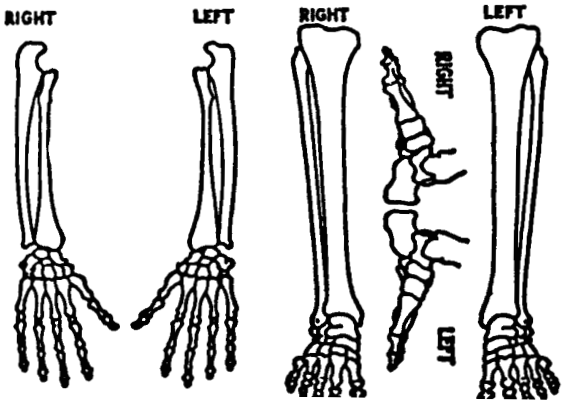
6. State the causes of loss of vision.

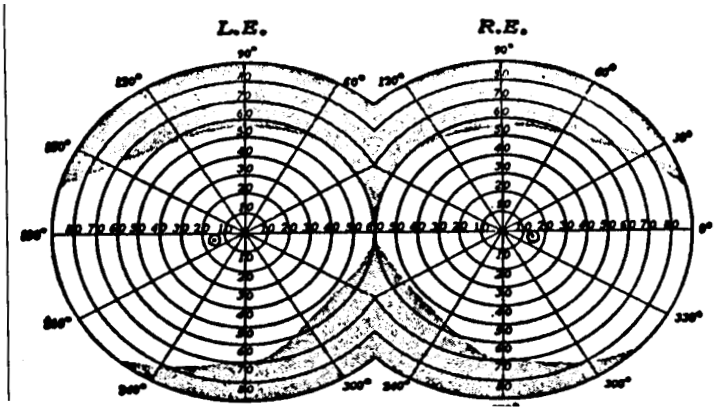
7. Indicate whether recovery of useful vision is possible by operation or treatment.

O.D. ☐ Operation ☐ Treatment

O.S. ☐ Operation ☐ Treatment

7a. If fields of vision are contracted, show contraction on chart below.





8. (a) Was the injury described solely responsible for the loss? _____

(b) If not, give the particulars of any contributing cause or causes? _____

_____

Signed _____

(Attending Physician)

Address _____

_____

Date _____ (Back) Phone No. _____

For residents of all states *EXCEPT* California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, Oregon, and Virginia: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

For residents of New Jersey, Arkansas, New Mexico, and Louisiana: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading information to an Insurance Company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

Date _____ **Claimant Signature** _____

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Hartford Life Insurance Company
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Hartford, CT 06104-2999

MAIL COPY TO:
Employee Insurance Program
P. O. Box 11661
Columbia, SC 29211